SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Filing at a Glance

Company: Americo Financial Life and Annuity Insurance Company

Product Name: Term App 2008	SERFF Tr Num: AFLC-125823461	State: ArkansasLH
TOI: L04I Individual Life - Term	SERFF Status: Closed	State Tr Num: 40305
Sub-TOI: L04I.500 Other	Co Tr Num: 20021	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Kristi Dingus	Disposition Date: 10/01/2008
	Date Submitted: 09/19/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Term App 2008	Status of Filing in Domicile: Pending
Project Number: 20021	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: filing submitted simultaneously in our state of domicile, Texas
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/01/2008	
State Status Changed: 10/01/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

Enclosed for your review and approval is life application form AAA5089 (2008). This is a new form and it does not contain any unusual or controversial elements. Individual agents of our Company will submit this form to the general public. This form achieves a Flesch readability score of 50.7.

Form AAA5089 (2008) will be used to apply for term life policy CAR174 (02/2005), approved for use in your state on July 12, 2007.

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

This form is exempt in Texas, our state of domicile, and we have submitted it as such simultaneously with this filing, pursuant to the statutes of that state.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your jurisdiction. If you have any questions or require any additional information, please contact me.

Thank you in advance for your assistance and consideration.

Company and Contact

Filing Contact Information

Kristi L Dingus, Senior Compliance Analyst - Filing	kristi.dingus@americo.com	
300 W. 11th Street	(816) 391-2719 [Phone]	
Kansas City, MO 64199	(816) 391-2246[FAX]	

Filing Company Information

Americo Financial Life and Annuity Insurance Company	CoCode: 61999	State of Domicile: Texas
300 West 11th Street	Group Code: 449	Company Type:
Kansas City, MO 64105	Group Name:	State ID Number:
(816) 391-2719 ext. [Phone]	FEIN Number: 35-0810610	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	1 x $50.00 = $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Americo Financial Life and Annuity Insurance Company	$50.00	09/19/2008	22612101

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/01/2008	10/01/2008

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Disposition

Disposition Date: 10/01/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Form	Term Life Insurance Application		Yes

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Form Schedule

Lead Form Number: AAA5089 (2008)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AAA5089 (2008)	Application/ Enrollment Form	Term Life Insurance Application	Initial		57	Application AAA5089 (2008).pdf

Application for Simplified Issue

Term Life Insurance

AAA5089 (2008)

AMERICO

1. PROPOSED INSURED INFORMATION

a. Proposed Insured's Name *(Last, First, MI)*

b. ☐ Single ☐ Married

c. ☐ Male ☐ Female

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

e. Home Phone

f. Work Phone

g. Email Address

h. How long at current address? _____ *If less than 5 years at current address, prior address required.*

i. Social Security Number

j. Date of Birth *(MM/DD/YYYY)*

k. Age

l. Place of Birth *(City, State, Country)*

m. Is the Proposed Insured currently employed? ☐ Yes ☐ No

n. Occupation

o. Annual Salary

2. PRODUCT INFORMATION

a. Product Name

[☐ HMS 15/15] [☐ HMS 15/5]
[☐ HMS 20/20] [☐ HMS 20/5]
[☐ HMS 25/25] [☐ HMS 25/5]
[☐ HMS 30/30] [☐ HMS 30/5]
[Other_____]

b. Payment Information

Face Amount $ _____

Mode Premium $ _____

Mode: [☐ Monthly Bank Draft] [☐ Quarterly]
[☐ Semiannually] [☐ Annually]

c. Effective Date *(If not checked, will be "Issue Date". Date cannot be the 29th, 30th, or 31st of the month.)*

☐ Issue Date

☐ Save Age of _____

☐ Specific Date_____

3. RIDERS *(Verify that the rider is available for the product selected.)*

a. [☐ Accidental Death Benefit] .....[$_____]

b. [☐ Additional Insured Term Insurance*] .....[$_____]
[Additional Insured's Occupation] .....[_____]
[Additional Insured's Salary] .....[$_____]

c. [☐ Children's Term*] .....[$_____]

d. [☐ Critical Illness Accelerated Benefit†,‡] .....[$_____]

e. [☐ Disability Income†]
☐ [Primary Insured] [☐ 1 Year ☐ 2 Years] [$_____]
☐ [Additional Insured] [☐ 1 Year ☐ 2 Years] [$_____]

f. [☐ Return of Premium]

g. [☐ Waiver of Premium‡]

h. [☐ Other _____]

[*Complete section 4 of this application. †Supplemental application required. ‡Critical Illness Accelerated Benefit and Waiver of Premium riders cannot be issued on the same policy.]

4. ADDITIONAL INSURED(S) *(To include Additional Insured and Children's Term Rider.)*

Name of Other Proposed Insured *(Last, First, MI)*	Date of Birth *(MM/DD/YYYY)*	State of Birth	Sex	Height	Weight *(lbs.)*	Social Security Number	Relationship to Primary Proposed Insured
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			
			☐M ☐F	' "			

5. BENEFICIARY INFORMATION (*Include percentage shares. If shares are not given, they will be equal.)*

If not specified, all beneficiaries will be Primary.	Name	Social Security Number or Taxpayer ID	Relationship	Date of Birth	% of Share *(Must total 100%)*
☐Primary					
☐Primary ☐Contingent					
☐Primary ☐Contingent					
☐Primary ☐Contingent					

6. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION

	Yes	No
a. Are any other applications for life or supplemental health insurance pending with other companies?	☐	☐
b. Are there any existing life insurance policies or annuities on the life of any Proposed Insured? *If Yes, provide information below.*	☐	☐
c. Will the life insurance policy applied for replace, or otherwise reduce in value, any existing life insurance policies or annuities now in force?	☐	☐

If Yes to 6b or 6c, complete applicable Replacement Notice. Application and Replacement Notice form must be dated on the same date.

d. Is this an internal replacement? *If Yes, include a Surrender form or Absolute Assignment form for the life insurance or annuity being replaced.*	☐	☐
e. If current life insurance or annuity is being replaced, indicate the amount of surrender charges that will be assessed. $ _____		

Insured's Name *(Last, First, MI)*	Company	Owner	Amount	Accidental Death Benefit	Policy Date *(MM/DD/YYYY)*

7. OWNER INFORMATION *(If different from the Proposed Insured.)*

a. Owner's Name *(Last, First, MI)*	b. Relationship to Proposed Insured	c. SSN or Taxpayer ID

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

e. How long at current address? _____ *If less than 5 years at current address, prior address required.*

f. Home Phone	g. Work Phone	h. Date of Birth *(MM/DD/YYYY)*	i. Place of Birth *(City, State, Country)*

8. PAYOR INFORMATION *(If different from the Proposed Insured and Owner.)*

a. Payor's Name *(Last, First, MI)*	b. Relationship to Proposed Insured	c. SSN or Taxpayer ID

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

e. How long at current address? _____ *If less than 5 years at current address, prior address required.*

9. SPECIAL REQUESTS

PERSONAL HISTORY *(Provide details of all "Yes" answers in the History Details section below.)*

	Yes	No
10. Has any Proposed Insured ever been declined, postponed, rated, or modified for insurance?	☐	☐
11. Within the past 2 years, has any Proposed Insured:		
a. made any flights as a pilot, student pilot, or member of a flight crew? *If Yes, complete Aviation Questionnaire.*	☐	☐
b. engaged in the following hazardous sports: bungee or base jumping, parachuting, hang gliding; competitive skiing/snowboarding (such as heli-skiing or ski jumping); diving activities (such as scuba, cave diving, or underwater photography); canyoning, kayaking, or white water rafting; organized racing (such as automobiles, drag racers, or motorcycles); rock or mountain climbing, rodeo riding, or any other hazardous sport/activity? *If Yes, complete Sports Questionnaire.*	☐	☐
12. Within the past 7 years, has any Proposed Insured been convicted of, pleaded guilty to, or entered a plea of no contest to any felony?	☐	☐
13. Is any Proposed Insured currently on probation or been placed on probation within the last 12 months?	☐	☐
14. Within the next 2 years, does any Proposed Insured intend to work, travel, or reside outside of the United States for more than 30 days? *If Yes, where? Provide details below.*	☐	☐
15. Has any Proposed Insured:		
a. had a driver's license suspended or revoked within the last 5 years?	☐	☐
b. been convicted of reckless driving or driving under the influence of alcohol or drugs in the past 5 years?	☐	☐

16. Driver's License Number(s) during the past five (5) years:

Name of Proposed Insured(s) on Driver's License	Driver's License Number	State Issued

PERSONAL HISTORY DETAILS

Question #	Insured's Name	Dates	Details

MEDICAL HISTORY *(Provide details of all "Yes" answers in the History Details section below.)*

	Yes	No
17. Proposed Insured's Height:		
18. Proposed Insured's Weight:		
19. Has any Proposed Insured used cigarettes, cigars, pipes, chewing tobacco, nicotine patches, snuff, nicotine chewing gum, or other products containing nicotine within the last 12 months?	☐	☐
20. Within the past 7 years, has any Proposed Insured been treated for or been advised or diagnosed by a medical professional to seek treatment for, or reduce or discontinue the intake of alcohol? *If Yes, complete alcohol usage questionnaire.*	☐	☐
21. Within the past 7 years, has any Proposed Insured been treated for or been advised or diagnosed by a medical professional to seek treatment for the intake of prescription drugs? *If Yes, complete drug questionnaire.*	☐	☐
22. Within the past 7 years, has any Proposed Insured used: heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine and cocaine derivatives, crack, barbiturates, amphetamines, methamphetamines, or hallucinogens or any other illegal, restricted, or controlled substances? *If Yes, complete drug questionnaire.*	☐	☐
23. Within the past 7 years, has any Proposed Insured been diagnosed with or been advised to have or had treatment for:		
a. high blood pressure, heart disease or disorder, heart surgery including bypass, angioplasty or stent placement, chest pain, stroke, circulatory, blood vessel or blood disorders?	☐	☐
b. lung or respiratory disorder, COPD, emphysema, current use of oxygen, shortness of breath, or sleep apnea?	☐	☐
c. cancer, leukemia, melanoma, or any other internal cancer?	☐	☐
d. diabetes?	☐	☐
e. digestive disorder, kidney or liver disease to include hepatitis, Crohn's disease or ulcerative colitis, gastrointestinal bleeding, or unexplained weight loss?	☐	☐
f. alzheimer's disease, dementia, nervous system disorder, emotional or psychiatric disorder, paralysis, sexually transmitted disease, chronic fatigue syndrome, lupus, or any blood disorders or birth defects?	☐	☐
g. rheumatoid arthritis, disease, or disorder of the bones or muscles?	☐	☐
h. any disease or disorder not mentioned above?	☐	☐
24. Within the past 7 years, has any Proposed Insured consulted a physician, had tests performed such as an EKG, echocardiogram, X-ray, blood tests, or been hospitalized for any reason?	☐	☐
25. Has any Proposed Insured ever been diagnosed as having, or been told by a medical professional that you have, or been treated by a medical professional for, Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or any immune deficiency Related disorder or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐
26. Do any of the Proposed Insured(s):		
a. currently use prescription medicines? *If Yes, list each medication and describe the reason for its use.*	☐	☐
b. currently have a personal physician? *If Yes, list name, address, and telephone number along with date, reason, and results of last consultation.*	☐	☐

MEDICAL HISTORY DETAILS

Please provide details of all "Yes" answers in the area below. *(Attach a separate sheet if more space is needed; additional sheet MUST be signed and dated by applicable Proposed Insured/Owner to avoid amendments.)*

Question #	Insured's Name	Dates/ Duration	Details/Results	Name, Address, and Telephone Number of Attending Physician

AUTHORIZATION AND ACKNOWLEDGMENT

I/We authorize any insurance or reinsurance company, employer, licensed medical physician, medical professional, hospital, medical facility, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or the Medical Information Bureau that has any record of information about me/us or my/our minor children who are to be insured, to give Americo Financial Life and Annuity Insurance Company (Americo), its reinsurers or its authorized representatives, information about other insurance coverage, employment, age, general character, motor vehicle records, habits, court records, foreign travel, finances, participation in hazardous activities, medical care or advice about any physical or mental condition, including information about drugs and alcoholism Americo requires to determine insurability if used for determining claims eligibility, no longer than the duration of the claim.

Americo may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have life insurance or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required.

I/We have received a copy of the Notice of Insurance Information Practices. I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for 2 years from the date signed. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf. I/We understand that disclosure of information to Americo may subject the information to redisclosure in accordance with Americo's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

IN ACCORDANCE WITH STATE LAW, WE MUST PROVIDE YOU WITH THE FOLLOWING FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DC Residents Only: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

KY & OH Residents only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NM Residents only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

TN Residents only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

The USA PATRIOT ACT requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

Request for owner's taxpayer identification number and certification: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the company's underwriting requirements nor make or change any contract. The company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application.

I/We represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that Americo can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. I/WE AGREE THAT ALL ANSWERS TO THE PERSONAL HISTORY QUESTIONS ON PAGE 2 AND TO MEDICAL HISTORY QUESTIONS ON PAGE 3 OF THIS APPLICATION, WHICH IS SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.

Signed at (City and State)_____ on (Month/Day/Year) _____

_____ _____

Signature of Proposed Insured | Signature of Owner (*If different from the Proposed Insured)*

_____ _____

Signature of Additional Proposed Insured | Signature of Witnessing Agent *(Required)*

AGENT'S REPORT

Important Note: Agent's Report must be completed and submitted with all applications

Proposed Insured's Name: _____

	Yes	No
1. Are you related to the Proposed Insured(s)?	☐	☐
If Yes, provide relationship: _____		
2. How long have you known the Proposed Insured(s)? _____		
3. Did the applicant approach you to purchase insurance? *(If Yes, list their stated need for the insurance in the Agent Comments/Remarks section below.)*	☐	☐
4. At the time this application was taken, were all of the Proposed Insureds present and did you witness their signatures?	☐	☐
5. Did the Proposed Insured(s) directly respond to you regarding each application question?	☐	☐
6. Was a government-issued picture ID requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor *(if different than the Proposed Insured)*?	☐	☐

Provide details of all NO answers to questions 4-6 in the Agent Comments/Remarks section below.

Replacement Information	Yes	No
7. Does the applicant have any existing life insurance or annuities on the life of any Proposed Insured?	☐	☐
8. Will the life insurance certificate applied for replace, or otherwise reduce in value, any life insurance or annuities now in force? *(If Yes to either question 7 or 8, complete applicable replacement form. Provide copies of replacement forms to the Owner and the Company.)*	☐	☐

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured(s), that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the "Agent Comments/Remarks" section above.

Print Agent's Name	Agent's Signature	Americo Agent Number	% Split

Writing Agent's Phone Number	Writing Agent's Fax Number	Writing Agent's Email Address

Does Americo have your current contact information? If not, email: licensing@americo.com.

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AFLC-125823461*	*State:*	*Arkansas*
Filing Company:	*Americo Financial Life and Annuity Insurance Company*	*State Tracking Number:*	*40305*
Company Tracking Number:	*20021*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.500 Other*
Product Name:	*Term App 2008*		
Project Name/Number:	*Term App 2008/20021*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 09/18/2008

Comments:

Attachments:

Readability Cert.pdf

AR Cert of Compliance w- Reg 19.pdf

Review Status:

Satisfied -Name: Statement of Variability 09/19/2008

Comments:

Attachment:

Stmt of Variability - 5089 (2008).pdf

READABILITY CERTIFICATION

COMPANY: Americo Financial Life and Annuity Insurance Company

NAIC #: 0449-61999

I hereby certify that the form listed below has the following readability score as calculated by the Flesch Reading Ease Test.

Form Number	Form Description	Readability Score
AAA5089 (2008)	Term Life Insurance Application	56.8

Digitally signed by
Jack Fortini
Date: 2008.09.18
17:48:19 -05'00'

Jack L. Fortini

Vice President Legal & Secretary
Title

September 18, 2008
Date

ARKANSAS

CERTIFICATION OF COMPLIANCE

COMPANY: Americo Financial Life and Annuity Insurance Company

FORM TITLE: Term Life Insurance Application

FORM NUMBER: AAA5089 (2008)

I hereby certify that to the best of my knowledge and belief the above form submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Jack L. Fortini

Vice President – Legal & Secretary
Title

September 19, 2008
Date

Americo Financial Life and Annuity Insurance Company

STATEMENT OF VARIABILITY

AAA5089 (2008)
& variations thereof

PRODUCT INFORMATION. Product Name: The product names are bracketed to facilitate the removal of products that are discontinued or to add products as they become approved without re-filing. We will never add a product for which we have not received authorization from your jurisdiction (if required) to use.

PRODUCT INFORMATION. Payment Information. Mode: The premium mode is bracketed to facilitate any change to availability of payment mode. If availability of a payment mode is eliminated, it will be eliminated for all new applicants. Americo will never administer in a discriminatory manner.

RIDERS. a. – h.: The rider names are bracketed to facilitate the removal of products that are discontinued or to add products as they become approved without re-filing. We will never add a product for which we have not received authorization from your jurisdiction (if required) to use.

RIDERS. [*Complete section 4 of this application. †Supplemental application required. ‡Critical Illness Accelerated Benefit and Waiver of Premium riders cannot be issued on the same policy.]: Inclusion of these statements is dependent on the availability of each of the riders noted.